

Patient Registration Form / Forma de Registración del Paciente

Patient Information / Información del Paciente		
Last Name / Apellido:	First Name / Primer Nombre:	Middle / Segundo Nombre:
Sex / Sexo: <input type="checkbox"/> Female / Femenino <input type="checkbox"/> Male / Masculino	Birthdate / Fecha de Nacimiento:	SSN / Número Seguro Social:
Address / Dirección:		
City / Ciudad:	State / Estado:	Zip / Código Postal:
Home Phone / Teléfono Casa:	Work Phone / Teléfono Trabajo:	Cell Phone / Teléfono Cell:
Primary / Primario <input type="checkbox"/>	Primary / Primario <input type="checkbox"/>	Primary / Primario <input type="checkbox"/>
Email / Correo Electrónico:	Language / Idioma:	Marital Status / Estado Civil:
Ethnicity / Nacionalidad:	Race / Raza:	Religion / Religión:
Employment Status / Estado de Empleo: <input type="checkbox"/> Full Time / Tiempo Completo <input type="checkbox"/> Part Time / Tiempo Parcial <input type="checkbox"/> Retired / Jubilado		Employer Name / Nombre del Empleador:
Emergency Contact / Contacto de Emergencia:		
Relationship to Patient / Relación al Paciente:		Phone / Teléfono:
Primary Care Physician / Médico de Atención Primaria:		Phone / Teléfono:
Responsible Party / Persona Responsable		
Last Name / Apellido:	First Name / Primer Nombre:	
Sex / Sexo: <input type="checkbox"/> Female / Femenino <input type="checkbox"/> Male / Masculino	DOB / Fecha de Nacimiento:	SSN / Número Seguro Social:
Address / Dirección:		
City / Ciudad:	State / Estado:	Zip / Código Postal:
Home Phone / Teléfono Casa:	Work Phone / Teléfono Trabajo:	Cell Phone / Teléfono Cell:
Primary / Primario <input type="checkbox"/>	Primary / Primario <input type="checkbox"/>	Primary / Primario <input type="checkbox"/>
Employment Status / Estado de Empleo: <input type="checkbox"/> Full Time / Tiempo Completo <input type="checkbox"/> Part Time / Tiempo Parcial <input type="checkbox"/> Retired / Jubilado		Employer Name / Nombre del Empleador:

Primary Insurance Information / Información de Seguro Primario			
Insurance Name / Nombre del Seguro:		Policy Number / Número de Póliza:	
Group Number / Número de Grupo:		Group Name / Nombre de Grupo:	
Relationship to Insured / Relación al Asegurado:		Subscriber Name / Nombre del Asegurado:	
Sex / Sexo: <input type="checkbox"/> Female / Femenino <input type="checkbox"/> Male / Masculino	Birthdate / Fecha de Nacimiento:	SSN / Número Seguro Social:	
Address / Dirección:			
City / Ciudad:		State / Estado:	Zip / Código Postal:
Secondary Insurance Information / Información de Seguro Secundario			
Insurance Name / Nombre del Seguro:		Policy Number / Número de Póliza:	
Group Number / Número de Grupo:		Group Name / Nombre de Grupo:	
Relationship to Insured / Relación al Asegurado:		Subscriber Name / Nombre del Asegurado:	
Sex / Sexo: <input type="checkbox"/> Female / Femenino <input type="checkbox"/> Male / Masculino	Birthdate / Fecha de Nacimiento:	SSN / Número Seguro Social:	
Address / Dirección:			
City / Ciudad:		State / Estado:	Zip / Código Postal:
Accident Related / Relacionado a un Accidente			
Is this related to / Es Relacionado a: Worker's Comp / Compención de trabajo: _____ Auto _____ Other (please specify) / Otra razón: _____ _____		Date of Injury / Fecha de lesionamiento: _____ Auto Accident State / Estado del Accidente (si auto): _____ Claim Number / Numero de Reclamo: _____ Bill to / Mandar Factura a: _____ _____	
<p>Signature / Firma: _____ Date / Fecha: _____</p>			

Authorization to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. There is potential for re-disclosure. The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Notice of Privacy Practices

We are required to provide you with a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" letter provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Bon Secours Upstate OB-GYN may or may not agree to restrict the use or disclosure of your protected health information. If Bon Secours Upstate OB-GYN agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Contact Mary Nickles at (864) 271-9780 to terminate this authorization.

Reservation of Right to Change Privacy Practices

Bon Secours Upstate OB-GYN reserves the right to modify the privacy practices outlined in the notice. I understand that Bon Secours Upstate OB-GYN will notify me of these changes via the method I have authorized or upon my next appointment.

Rights of the Individual

*You may inspect or copy the information used or disclosed under this authorization by contacting Mary Nickles at (864) 271-9780.

*You may refuse to sign this authorization. If you refuse to sign, Bon Secours Upstate OB-GYN, will not deny you treatment.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis: **If you wish a spouse, step-parent, child, secretary, friend, etc. to have access to appointment times, health information, and/or billing information, please lists them here.**

_____ may have access to: all info billing info only diagnosis/medical info
only

_____ may have access to: all info billing info only diagnosis/medical info
only

_____ may have access to: all info billing info only diagnosis/medical info
only

_____ may have access to: all info billing info only diagnosis/medical info
only

_____ may have access to: all info billing info only diagnosis/medical info
only

2. You're billing statements and/or correspondence from our office will be sent to the address provided by you on your patient information sheet. All clinical correspondence will be marked "CONFIDENTIAL" when mailed directly from our office.

3. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are done by telephone and a brief, nonspecific message may be left on your answering machine or voicemail. The home number you provided on your patient information sheet will be used to contact you. We may also leave messages regarding treatment and/or other information pertinent to your healthcare and payment for your care provided at Bon Secours Upstate OB-GYN.

If you do not wish to be contacted in this manner, how else may we contact you?

I have reviewed this consent form, received the notice entitled "Notice of Privacy Policies and Practices" and give my permission to Bon Secours Upstate OB-GYN to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Print/Type)	Signature of Patient OR Signature of Patient Representative	Date
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Relationship of Patient Representative to Patient

Version 1.0 Approved 07/03/2018